Speech Therapy Outpatient – Fee-For-Service Billing and Policy Manual

Provider Qualifications

Eligible Providers

Eligible providers may be individual practitioners or may be employed by home care agencies, children's developmental service agencies, health departments, Federally Qualified Health Centers (FQHC), clinics, or hospital outpatient facilities. The provider agency or the individual provider must verify that rendering providers meet the following qualifications:

Speech-Language Pathologists (SLPs) must have a current certification by the Colorado Department of Regulatory Agencies (DORA) pursuant to the Speech-language Pathology Practice Act.

Speech-Language Pathology Assistants are support personnel who, following academic and/or on-the-job training, perform tasks prescribed, directed, and supervised by DORA-certified speech-language pathologists. Speech-language pathologists must follow the ASHA guidelines on the training, use, and supervision of assistants. (Assistants cannot render services under the Home Health benefit of the Medical Assistance Program.) **Speech-language pathology assistants** must practice under the general supervision of a Colorado registered speech-language pathologist.

Clinical Fellows, practicing under the general supervision of a DORA-certified speech-language pathologist may provide speech therapy services.

Provider Participation

Providers must be enrolled as a Colorado Medical Assistance Program provider in order to:

- Treat a Colorado Medical Assistance Program member
- Submit claims for payment to the Colorado Medical Assistance Program

All speech therapists must submit a completed provider enrollment packet to become a Colorado Medical Assistance Program provider. Providers will find enrollment information in the Provider Services Enrollment section of the Department's website (colorado.gov/hcpf). Enrollment documents may be downloaded and must be mailed to:

Xerox State Healthcare
Colorado Medical Assistance Program Provider Enrollment
PO Box 1100
Denver, CO 80201-1100

General Policies

1. The term "Outpatient" means any therapy which is not performed in an Inpatient Hospital or School setting, or by a Home Health Agency.
2. Speech-language pathologists not employed by an agency, clinic, hospital, school district, or physician may bill the Colorado Medical Assistance Program directly. Providers should refer to the Code of Colorado Regulations, Qualified Non-Physician Practitioners Eligible to Provide Physician's Services (10 CCR 2505-10, Section 8.2003.C), for specific information when providing speech therapy.

3. All Outpatient Speech Therapy services must have a written order/prescription/referral by any of the following:
    - Physician (M.D. or D.O.)
    - Physician Assistant
    - Nurse Practitioner
    - An approved Individualized Family Service Plan (IFSP) for Early Intervention Speech Therapy
4. Speech Therapy services must be medically necessary to qualify for Medicaid reimbursement. Medical necessity, as defined under program rule 8.200.1, physician services, means:

    A covered service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury or disability; and for which there is no other equally effective or substantially less costly course of treatment suitable for the member's needs.
5. Speech therapy services must always be rendered in conjunction with a written evaluation and Plan of Care. This Plan of Care must outline:
    - Specific treatment goals
    - Proposed interventions/treatment to be provided during the episode of care
    - Proposed duration and frequency of each service to be provided
    - Estimated duration of episode of care

    The therapist's Plan of Care must be reviewed, revised if necessary, and signed, as medically necessary by the member's physician, or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law at least once every 90 days. The care plan should not cover more than a 90-day period or the time frame documented in the Individual Family Service Plan (IFSP). (Senate bill 07-004 states the IFSP "shall qualify as meeting the standard for medically necessary services." Therefore no physician is required to sign a work order for the IFSP.)
6. Pursuant to the Affordable Care Act's requirements that State Medicaid Agencies ensure correct ordering, prescribing, and referring (OPR) National Provider Identification (NPI) numbers be on the claim form (42 CFR §455.440):
    - All Outpatient Speech Therapy claims must contain the valid NPI number of the OPR physician, physician assistant, nurse practitioner, or provider associated with an Individualized Family Service Plan (IFSP), in accordance with Program Rule 8.125.8.A.
    - All physicians, physician assistants, nurse practitioners, or providers associated with an IFSP who order, prescribe, or refer Outpatient Speech Therapy services for Medicaid members must be enrolled in Colorado Medicaid (42 CFR §455.410), in accordance with Program Rule 8.125.7.D. OPR Providers can begin enrollment on Colorado Medicaid's website.
        - The new enrollment requirement for OPR providers does not include a requirement to see Medicaid members or to be listed as a Medicaid provider for patient assignments or referrals.

    - Physicians or other eligible professionals who are already enrolled in Colorado Medicaid as participating providers and who submit claims to Colorado Medicaid are not required to enroll separately as OPR providers.
7. The term "valid OPR NPI number" means the registered NPI number of the provider that legitimately orders, prescribes, or refers the Outpatient Speech Therapy service being rendered, as indicated by the procedure code on the claim.
    - Claims without a valid OPR NPI number which are paid will then be subject to recovery.
    - Medical documentation must be kept on file to substantiate the order, prescription, or referral for Outpatient Speech Therapy. Claims lacking such documentation on file will be subject to recovery.
8. Colorado Medicaid recognizes that Outpatient Speech Therapy ordered in conjunction with an approved IFSP for Early Intervention may not necessarily have an ordering provider. Under this circumstance alone the rendering provider must use their own NPI number as the OPR NPI number.
    - Early Intervention Outpatient Speech Therapy claims must have modifier 'TL' attached on the procedure line item for Colorado Medicaid to identify that the services rendered were associated with an approved IFSP.
        - Any claim with modifier 'TL' attached must be for a service ordered by an approved IFSP and delivered within the time span noted in the IFSP.
        - If the OPR NPI on the claim is that of the rendering provider, and the claim does not have modifier 'TL' attached, the claim is subject to recovery.
9. Educational, personal need, and comfort therapies are not covered speech therapy benefits for any member regardless of age.
10. Therapies provided as part of a member's IEP (individualized education program) by a therapist in the school setting are not separately reimburseable. These services are paid for by the school district which is reimbursed by the Department. Providers may not submit claims for services performed in the school setting.
11. Reference the Speech-language and Hearing Services Benefit Coverage Standard found on our website for further coverage and policy information.

Payment for Covered Services

Regardless of whether Colorado Medicaid has actually reimbursed the provider, billing members for covered services is strictly prohibited. Balance billing is prohibited. If reimbursement is made, providers must accept this payment as *payment in full* (see Program Rule 8.012). The provider may only bill the member for services not covered by Colorado Medicaid.

- Members may be billed for non-covered services in accordance with C.R.S. 25.5-4-301(1)(a)(I).
    - *(1) (a) (I) Except as provided in section 25.5-4-302 and subparagraph (III) of this paragraph (a), no recipient or estate of the recipient shall be liable for the cost or the cost remaining after payment by medicaid, medicare, or a private insurer of medical benefits authorized by Title XIX of the social security act, by this title, or by rules promulgated by the state board, which benefits are rendered to the recipient by a provider of medical services authorized to render such service in the*

state of Colorado, except those contributions required pursuant to section 25.5-4-209 (1). However, a recipient may enter into a documented agreement with a provider under which the recipient agrees to pay for items or services that are nonreimbursable under the medical assistance program. Under these circumstances, a recipient is liable for the cost of such services and items.

- If Prior Authorization Requests (PAR) for services are required, the following policy applies:
  - Technical/lack of information (LOI) denial does not mean those services are not covered. Members may not be billed for services denied for LOI.
  - Services partially approved are still considered covered services. Members may not be billed for the denied portion of the request.
  - Services totally denied for not meeting medical necessity criteria are considered non-covered services.

For detailed coverage and service limitations, please refer to the Speech-language and Hearing Services Benefit Coverage Standard on the Department's website.

Rehabilitative Speech Therapy

In accordance with 10 CCR 2505-10 8.200.3.D.2.d.i, Rehabilitative speech therapy is a covered benefit under the following conditions. "Rehabilitative" means therapy that treats acute injuries and illnesses which are non-chronic conditions. Rehabilitative is therefore short-term in nature.

Member Eligibility

1. Adult Policy
   a. All Medicaid members age 21 and over may receive Rehabilitative speech therapy to treat non-chronic conditions and acute illness and injury.
2. Child Policy
   a. All Medicaid members age 20 and under may receive Rehabilitative speech therapy to treat non-chronic conditions and acute illness and injury.
3. The acute condition must be documented in all medical/treatment session notes, and must be accompanied by an order/referral/prescription by a licensed Colorado Medicaid enrolled physician, physician assistant, or nurse practitioner.

Habilitative Speech Therapy

In accordance with 10 CCR 2505-10 8.017.B, Habilitative speech therapy is a covered benefit under the following conditions. The Colorado Division of Insurance has defined "Habilitative" services to be:

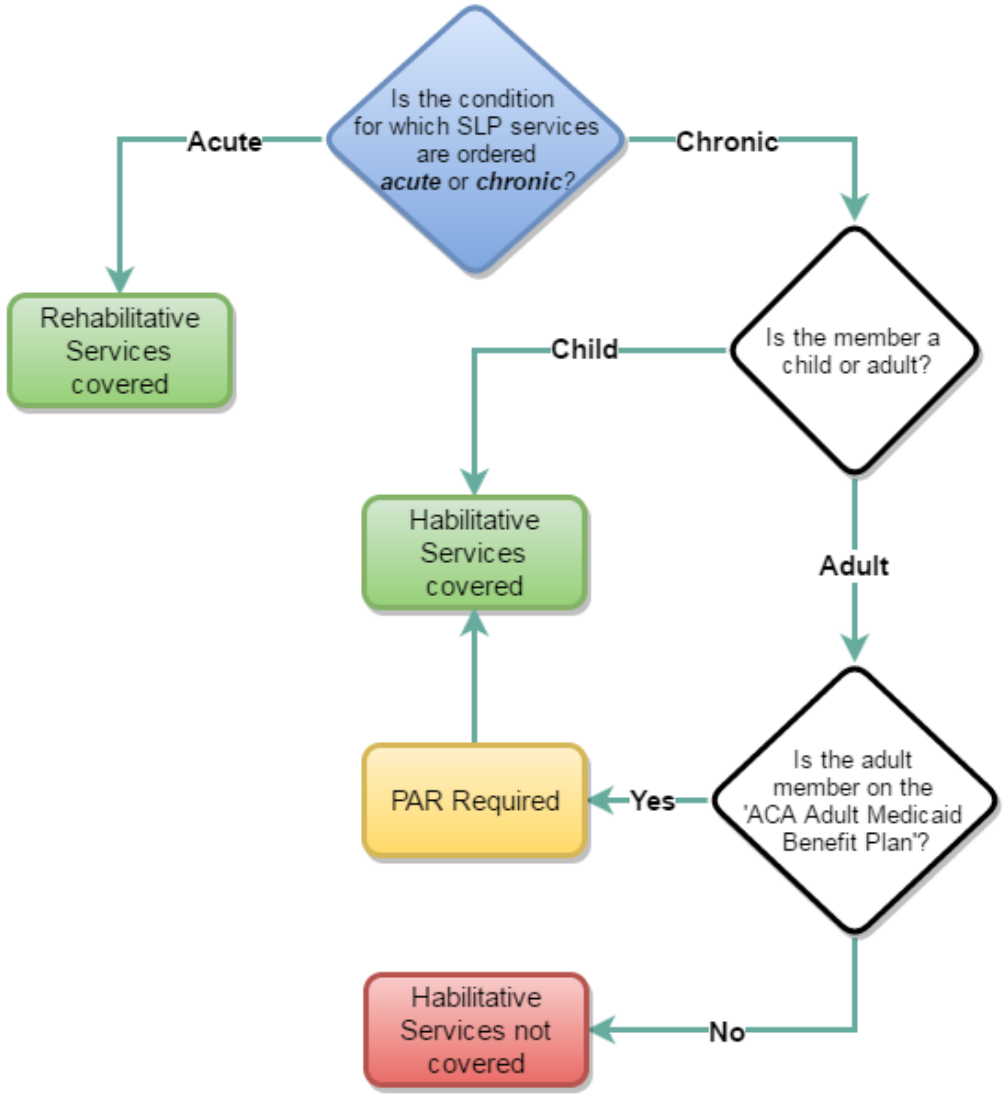
Services that help a person retain, learn, or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services offered in Colorado's Essential Health Benefits (EHB) benchmark plan. Parity in this context means of like type and substantially equivalent in scope, amount, and duration.

"Habilitative" means therapy that treats chronic conditions with the purpose of helping the member retain or improve skills and functioning that are affected by the chronic condition. Habilitative therapy may therefore be long-term in nature.

Member Eligibility

1. Adult Policy
    a. All Medicaid members ages 21 and over are considered adults. Only adults who are on the ACA Adult Medicaid Benefit Plan (Medicaid expansion members) may receive Habilitative speech therapy.
        i. Providers must check a member's eligibility status through the provider web portal to verify if this benefit is covered. Only the following eligibility response indicates Habilitative speech therapy is covered: "this EXPANSION MEMBER receives the ACA ADULT MEDICAID BENEFIT PLAN."
    b. Prior Authorization Requests for Habilitative speech therapy are required for adults.
    c. The chronic condition must be documented in all medical/treatment session notes, as well as in the Prior Authoritzation Request, and must be accompanied by an order/referral/prescription by a licensed Colorado Medicaid enrolled physician, physician assistant, or nurse practitioner.
    d. Eligible members may receive Habilitative speech therapy in addition to Rehabilitative speech therapy.
2. Child Policy
    a. All Medicaid members aged 20 may receive Habilitative speech therapy to treat a chronic condition which requires ongoing speech therapy to prevent against the loss of functional ability.
    b. The chronic condition must be documented in all medical/treatment session notes and must be accompanied by an order/referral/prescription by a licensed Colorado Medicaid enrolled physician, physician assistant, or nurse practitioner.
    c. Prior Authorization Requests are not required for children.
    d. Eligible members may receive Habilitative speech therapy in addition to Rehabilitative speech therapy.

Coverage Diagram



Benefit Limitations

1. Rehabilitative and Habilitative speech therapy is limited to five (5) units of service per date of service.
2. Eligible members may not receive both Rehabilitative and Habilitative speech therapy services on the same date of service.

Additional Limitations and Notes

- Habilitative therapies are not an Inpatient or Home Health benefit.
- Habilitative therapies are not a benefit if provided in nursing facilities; Rehabilitative PT, OT, ST will remain benefits.
- Habilitative therapies should not to be confused with Habilitation services found within Home and Community Based Services (HCBS) waivers.

Assistive Technology Assessments

The following billing policies are effective for CPT procedure code **97755** to accommodate HB14-1211. HB14-1211 requires that all Medicaid members seeking complex rehabilitation technology must have an initial Assistive Technology Assessment (complex rehabilitative technology evaluation/assessment) prior to receiving complex rehabilitation technology, and follow-up assessments, as needed. Only licensed speech, physical, and occupational therapists may render this specialty evaluation.

All providers using procedure code **97755** must follow these guidelines. The Department recognizes that only a portion of Assistive Technology Assessments will be used for complex rehabilitation technology evaluation/assessment. Providers will be asked upon PAR submission if the service is for a complex rehabilitation technology assessment.

Policy	**Notes**
Complex rehabilitation technology evaluations / assessments are billed using **only 97755**.	Combinations of procedure codes, including procedure code **97542**, for the purposes of complex rehabilitation technology evaluation / assessment are not allowed.
97755 always requires a Prior Authorization Request (PAR).	PARs must be submitted electronically using ColoradoPAR. Details are found here.
Member daily limit of **97755** is 20 units.	Up to five hours of assessment is allowed per date of service.
Member yearly limit of **97755** is 60 units.	Members may have up to 60 units of procedure code **97755** per State Fiscal Year (July 1 – June 30). This limit will reset with the start of each new State Fiscal Year.

PARs for **97755** must comply with the following policies:

- Must have a current prescription/referral for an Assistive Technology Assessment from the member's primary care physician.
- May indicate up to one year duration.
- May indicate initial/new assessments or follow-up assessment visits.
- Only one active PAR for **97755** is allowed per member, per span of time. Overlapping **97755** PAR requests will be denied.
- Initial speech therapy evaluation services, such as **92521**, are not required prior to requesting **97755**.
- **97755** is **separate** from physical and occupational therapy (PT/OT) and is not part of the PT/OT benefit limitation.
- PARs for **97755** should be submitted independently from other services. The Medical PAR type should be selected for **97755** at ColoradoPAR.com.

- **97755** performed by a Speech Therapist is considered Rehabilitative speech therapy and is covered for both adults and children.

If a member requires further assessment by a different provider not indicated on the original PAR, and that PAR is still active, then it must be closed by the original requesting provider. Once closed a new PAR can be submitted. Members may request a 'change of provider' on their PAR by contacting the vender directly. Please see the Prior Authorization Request section of this manual.

Daily Unit Limits

- Speech Therapy is limited to five (5) units of service per date of service. Some specific daily limits per procedure code apply. Please see the table below.
- While a maximum of five units of service is allowed per date of service, providers are required to consult the American Medical Association's (AMA) Current Procedural Terminology (CPT) manual for each coded service. Some codes represent a treatment session without regard to its length of time (one unit maximum) while other codes may be billed incrementally as "timed" units.
- Members determined to need a speech generating device (HCPCS codes **E2500**, **E2502**, **E2504**, **E2510**, **E2211**, **E2512**, and **E2599**) should be referred to a Medicaid participating medical supplier to be prior authorized.
- All claims must meet eligibility and claim submission requirements (e.g. timely filing, third party resources payment pursued, required attachments included, etc.) before payment can be made.

Coding Tables

Required Billing Modifier Code Table	
Benefit	**Required Modifiers**
Speech Therapy - Rehabilitative	GN
Speech Therapy - Habilitative	GN + HB
Speech Therapy – Early Intervention	GN + TL

Covered Speech Therapy Procedure Codes			
Brief Description	**Procedure Code**	**Unit Limits** **Max # units per member, per provider, per DOS**	**Prior Authorization Required**
Evaluation of speech fluency (e.g. stuttering, cluttering)	**92521**	1	Adult-Habilitative Only
Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)	**92522**	1	Adult-Habilitative Only

Covered Speech Therapy Procedure Codes			
Brief Description	**Procedure Code**	**Unit Limits** **Max # units per member, per provider, per DOS**	**Prior Authorization Required**
Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)	**92523**	1	Adult-Habilitative Only
Behavioral and qualitative analysis of voice and resonance	**92524**	1	Adult-Habilitative Only
Treatment of speech, language, voice, communication and/or auditory disorder; individual.	**92507**	1	Adult-Habilitative Only
Speech/hearing treatment, group, 2 or more individuals	**92508**	1	Adult-Habilitative Only
Laryngeal function studies	**92520**	1	Adult-Habilitative Only
Treatment of swallowing dysfunction or oral.	**92526**	1	Adult-Habilitative Only
Oral speech device evaluation	**92597**	1	Adult-Habilitative Only
Evaluate for device	**92605**	1	Adult-Habilitative Only
Non-speech device service	**92606**	1	Adult-Habilitative Only
Evaluation for speech generating device, first hour	**92607**	1	Adult-Habilitative Only
Additional 30 minutes of evaluation for 92607	**92608**	1	Adult-Habilitative Only
Use of speech device service	**92609**	1	Adult-Habilitative Only
Evaluation of oral and pharyngeal swallowing function	**92610**	1	Adult-Habilitative Only
Motion fluoroscopic evaluation of swallowing function	**92611**	1	Adult-Habilitative Only

Covered Speech Therapy Procedure Codes			
Brief Description	**Procedure Code**	**Unit Limits** **Max # units per member, per provider, per DOS**	**Prior Authorization Required**
Flexible fiber optic endoscopic evaluation by cine or video recording	**92612**	1	Adult-Habilitative Only
Flexible fiber optic endoscopic laryngeal sensory testing by cine or video recording	**92614**	1	Adult-Habilitative Only
Evaluation of auditory rehab status; first hour	**92626**	1	Adult-Habilitative Only
Each additional 15 minutes of 92626	**92627**	4	Adult-Habilitative Only
Assessment of aphasia, per hour	**96105**	2	Adult-Habilitative Only
Developmental testing; extended with interpretation and report, per hour	**96111**	1	Adult-Habilitative Only
Development of cognitive skills, per 15 minutes	**97532**	3	Adult-Habilitative Only
Assistive technology assessment, each unit 15 minutes	**97755**	20 per day, 60 per fiscal year	Always
Telehealth, originating site facility fee	**Q3014**	1	Adult-Habilitative Only

National Correct Coding Initiative (NCCI)

National Correct Coding Initiative Procedure-To-Procedure (PTP) and Medically Unlikely Edits (MUE) edits apply to certain combinations of speech therapy procedure codes. Please refer to the Medicaid.gov website on NCCI edits for the NCCI Policy Manual, a complete list of impacted codes, guidance on bypass modifier use, and general information.

- Policy guidance for NCCI provided in this manual does not supersede Federal NCCI policy. It is published to assist providers in understanding how the Colorado Medicaid Speech Therapy benefit is affected by NCCI edits and policy.
- Although every effort is made to guide providers accordingly, this manual may not always reflect the most up to date NCCI policies, nor is it an exhaustive list of any edit/policy that may affect the speech therapy benefit. Providers should **always** reference the Medicaid.gov website for the most current NCCI policies as those policies may change.

- Colorado Medicaid does not create NCCI policy.
- All providers are required to comply with NCCI policy.

Pursuant to the NCCI Policy Manual (Current Revision 1-1-2016, Chapter XI – Page 14):

a) Speech language pathologists may perform services coded as CPT codes **92507**, **92508**, or **92526**. They do not perform services coded as CPT codes **97110**, **97112**, **97150**, or **97530**, which are generally performed by physical or occupational therapists. Speech language pathologists should not report CPT codes **97110**, **97112**, **97150**, **97530**, or **97532** as unbundled services included in the services coded as **92507**, **92508**, or **92526**.

b) A single practitioner should not report CPT codes **92507** (treatment of speech, language, voice . . .; individual) and/or **92508** (treatment of speech, language, voice . . .; group) on the same date of service as CPT codes **97532** (development of cognitive skills to improve . . .) or **97533** (sensory integrative techniques to enhance . . .).
However, if the two types of services are performed by different types of practitioners on the same date of service, they may be reported separately by a single billing entity. For example, if a speech language pathologist performs the procedures described by CPT codes **92507** and/or **92508** on the same date of service that an occupational therapist performs the procedures described by CPT codes **97532** and/or **97533**, a provider entity that employs both types of practitioners may report both services utilizing an NCCI PTP-associated modifier.

c) Treatment of swallowing dysfunction and/or oral function for feeding (CPT code **92526**) may utilize electrical stimulation. The HCPCS code **G0283** (electrical stimulation (unattended), to one or more areas for indication(s) other than wound care...) should not be reported with CPT code **92526** for electrical stimulation during the procedure. The NCCI PTP edit (**92526**/**G0283**) for practitioner service claims does not allow use of NCCI PTP-associated modifiers with this edit because the same provider would never perform both of these services on the same date of service. However, the same edit for outpatient hospital facility claims does allow use of NCCI PTP-associated modifiers because two separate practitioners in the same outpatient hospital facility or institutional therapy provider might perform the two procedures for different purposes at different patient encounters on the same date of service.

Prior Authorization Requests (PARs) – Habilitative Speech Therapy Only

Independent speech therapists and outpatient hospital based therapy clinics providing Habilitative speech therapy must submit, and have approved, PARs for medically necessary services prior to rendering the services.

Prior Authorization Requests are approved for up to a twelve (12) month period (depending on medical necessity determined by the authorizing agency).

- Retroactive PAR requests will not be accepted.
- Overlapping PAR request dates for same provider types will not be accepted.

- Incomplete, incorrect or insufficient member information on a PAR request form will not be accepted.

Submit PARs for the number of units for each specific procedure code requested, not for the number of services. Modifiers must be included on both the PAR and claim submission. When submitting a PAR for either rehabilitative or habilitative services, the procedure codes must include GN + HB modifiers (e.g. 92507+GN+HB).

PAR requests must include:

- Legibly written and signed ordering practitioner prescription, to include diagnosis (preferably with ICD-10 code) and reason for therapy, the number of requested therapy sessions per week and total duration of therapy.
- The member's Physical or Occupational treatment history, including current assessment and treatment. Include duration of previous treatment and treating diagnosis.
- Documentation indicating if the member has received PT or OT under the Home Health Program or inpatient hospital treatment.
- Current treatment diagnosis.
- Course of treatment, measurable goals and reasonable expectation of completed treatment.
- Documentation supporting medical (physical NOT developmental) necessity for the course and duration of treatment being requested.
- Assessment or progress notes submitted for documentation, must not be more than sixty (60) days prior to submission of PAR request.
- If the PAR is submitted for services delivered by an independent therapist, the name and address of the individual therapist providing the treatment must be present in field #24 of the PAR.
- The billing provider name and address needs to be present in field #25 on the PAR.
- The Colorado Medical Assistance Program provider number of the independent therapist must be present in PAR field #28.
- The billing provider's Colorado Medical Assistance Program number must be present in field #29 of the PAR.

The authorizing agency reviews all completed PARs and approves or denies, by individual line item, each requested service or supply listed on the PAR. PAR status inquiries can be made through the Web Portal and results are included in PAR letters sent to both the provider and the member. **Read the results carefully as some line items may be approved and others denied. Do not render or bill for services until the PAR has been processed.**

The claim must contain the PAR number for payment.

Approval of a PAR does not guarantee Colorado Medical Assistance Program payment and does not serve as a timely filing waiver. Prior authorization only assures that the service is considered a benefit of the Colorado Medical Assistance Program. All claims, including those for prior authorized services, must meet eligibility and claim submission requirements (e.g. timely filing, third party resources payment pursued, required attachments included, etc.) before payment can be made.

If the PAR is denied, providers should direct inquiries to the authorizing agency:

ColoradoPAR Program
Provider Prior Authorization (PAR) Vendor for the Colorado Medical Assistance Program
Provider PAR Line: 888-801-9355
PAR Fax Line: 866-940-4288

The Colorado Medical Assistance Program PAR forms are available in the Provider Services Forms section or by contacting the ColoradoPAR Program at 888-801-9355 (toll free).

Providers can fax documents to the ColoradoPAR Program at 866-940-4288. Documents that may be compromised by faxing can be mailed to:

PAR Revisions

Please print "REVISION" in bold letters at the top and enter the PAR number being revised in box #7. Do not enter the PAR number being revised anywhere else on the PAR.

Paper Prior Authorization Request Instructional Reference

Field Label	Completion Format	Instructions
The upper margin of the PAR form must be left blank. This area is for authorizing agency use only.		
Invoice/Pat Account Number	Text	Optional Enter up to 12 characters (numbers, letters, hyphens) that help identify the claim or member.
Does Client Have Primary Insurance?	Check box ☐ Y ☐ N	Optional Enter an "X" in the appropriate box.
1. Client Name	Text	Required Enter the member's last name, first name, and middle initial.
2. Client Identification Number	1 letter followed by 6 numbers	Required Enter the member's state identification number. This number consists of a letter prefix followed by six numbers. Example: A123456.
3. Sex	Check box ☐ Y ☐ N	Required Enter an "X" in the appropriate box.
4. Date of Birth	6 digits (MMDDYY)	Required Enter the member's birth date using MMDDYY format. Example: January 1, 2015 = 010115.
5. Client Address	Characters: numbers and letters	Required Enter the member's full address: Street, City, State, and Zip code.
6. Client Telephone Number	Text	Optional Enter the member's telephone number.
7. Prior Authorization Number		System assigned Leave blank
8. Dates Covered by this Request	6 digits for From date and 6 digits for	Optional Enter the date(s) within which service(s) will be provided. If left blank, dates are

Field Label	Completion Format	Instructions
	Through date (MMDDYY)	entered by the authorizing agency. Authorized services must be provided within these dates.
9. Does Client Reside in a Nursing Facility?	Check box ☐ Y ☐ N	Required Check the appropriate box.
10. Group Home Name if Patient Resides in a Group Home	Text	Not applicable.
11. Diagnosis	Text	Required Enter the medical/physiological diagnosis code and sufficient relevant diagnostic information to justify the request. Include the prognosis. Provide relevant clinical information, other drugs or alternative therapies tried to treating the condition, results of tests, etc. to justify a Colorado Medical Assistance Program determination of medical necessity. Approval of necessity. Attach documents as required.
12. Requesting Authorization for Repairs	Text	Not applicable
13. Indicate Length of Necessity	Text	Not applicable
14. Estimated Cost of Equipment	Digits	Not applicable
15. Services to be Authorized	None	Preprinted Do not alter preprinted lines. No more than five items can be requested on one form.
16. Describe Procedure, Supply, or Drug to be Provided	Text	Required Enter the description of the service/procedure to be provided.

Field Label	Completion Format	Instructions
17. Procedure, Supply or Drug Code Required	HCPCS code	Enter the procedural code for each item that will be billed on the claim form. The authorized agency may change any code. The approved code(s) on the PAR form must be used on the claim form.
18. Requested Number of Services	Digits	Required Enter the number of units for supplies, services or equipment requested. If this field is blank, the authorizing agency will complete with one unit.
19. Authorized No. of Services	None	Leave blank The authorizing agency indicates the number of services authorized which may be more not equal number of requested in Field 18 (Number of Services).
20. A = Approved **D = Denied**	None	Leave blank Check the PAR on-line or refer to the PAR letter.
21. Primary Care Physician (PCP) Name	Text	Conditional Complete if member has a PCP.
Telephone Number	Text	Optional Enter the PCP's telephone number.
22. Primary Care Physician Address	Text	Conditional Complete if member has a PCP. Enter the PCP's complete address.
23. PCP Provider Number	8 Digits	Conditional Complete if member has a PCP. Enter the PCP's eight-digit Colorado Medical Assistance provider number. This number must be obtained by contacting the PCP for the necessary authorization.
24. Name and Address of Physician Referring for Prior Authorization	Text	Required Enter the complete name and address of the physician requesting prior

Field Label	Completion Format	Instructions
		authorization (the physician ordering/writing the prescription).
25. Name and Address of Provider Who will Bill Service	Text	Required Enter the name and telephone number of the provider who will be billing for the service.
26. Requesting Physician Signature	Text	Required The requesting provider must sign the PAR and must be the physician ordering the service. Under unusual circumstances, when the prescribing physician is not available, a legible copy of a signed prescription may be attached in place of the signature of the requesting provider. The written diagnosis must be entered in Field 11 (Diagnosis), even if a prescription form is attached. Do not send the original prescription; send a photocopy on an 8 ½ x 11 sheet. A rubber stamp facsimile signature is not acceptable on the PAR.
27. Date Signed	6 Digits	Required Enter the date the PAR form is signed by the requesting provider.
Telephone Number	Text	Required Enter the telephone number of the requesting provider.
28. Requesting Physician Provider Number	8 Digits	Required Enter the eight-digit Colorado Medical Assistance Program provider number of the requesting provider.
29. Billing Provider Number	8 Digits	Required Enter the eight-digit Colorado Medical Assistance Program provider number of the billing provider. All rendering and billing providers must be Colorado Medical Assistance program providers.

Field Label	Completion Format	Instructions
30. Comments	Text	Leave Blank This field is completed by the authorizing agency. Refer to the PAR response for comments submitted by the authorizing agent.
31. PA Number Being Revised	Text	Leave Blank This field is completed by the authorizing agency.

Billing Information

National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities (i.e., health plans, health care clearinghouses, and those health care providers who transmit any health information electronically in connection with a transaction for which the Secretary of Health and Human Services has adopted a standard) use NPIs in standard transactions.

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically prior authorized by the Department. Requests for paper claim submission may be sent to the Department's fiscal agent, Xerox State Healthcare, P.O. Box 90, Denver, CO 80201-0090. The following claims can be submitted on paper and processed for payment:

- Claims from providers who consistently submit 5 claims or fewer per month (requires prior approval)
- Claims that, by policy, require attachments
- Reconsideration claims

Paper claims do not require an NPI, but do require the Colorado Medical Assistance Program provider number. In addition, the UB-04 Certification document must be completed and attached to all claims submitted on the paper UB-04. Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required".

Electronic Claims

Instructions for completing and submitting electronic claims are available through the following:

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D (wpc-edi.com/)

- Companion Guides for the 837P, 837I, or 837D in the Provider Services Specifications section of the Department's Web site.
- Web Portal User Guide (via within the portal)

The Colorado Medical Assistance Program collects electronic claim information interactively through the Colorado Medical Assistance Program Secure Web Portal (Web Portal) or via batch submission through a host system. For additional electronic information, please refer to the Medicaid Provider Information manual located on the Department's website (www.colorado.gov/hcpf/billing-manuals)

Procedure/HCPCS Code Overview

The codes used for submitting claims for services provided to Colorado Medical Assistance Program members represent services that are approved by the Centers for Medicare and Medicaid Services (CMS) and services that may be provided by an enrolled Colorado Medical Assistance Program provider.

The Healthcare Common Procedural Coding System (HCPCS) is divided into two principal subsystems, referred to as level I and level II of the HCPCS.

Level I of the HCPCS is comprised of CPT, a numeric coding system maintained by the AMA.

The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT codes are identified using 5 numeric digits.

HIPAA requires providers to comply with the coding guidelines of the AMA CPT Procedure Codes and the International Classification of Disease, Clinical Modification Diagnosis Codes. If there is no time designated in the official descriptor, the code represents one unit or session. Providers should regularly consult monthly bulletins located in the Provider Services Bulletins section. To receive electronic provider bulletin notifications, an email address can be entered into the Web Portal in the *(MMIS) Provider Data Maintenance* area or by filling out a publication preference form. Bulletins include updates on approved procedure codes as well as the maximum allowable units billed per procedure.

CMS 1500 Paper Claim Reference Table

The following paper form reference table shows required, optional, and conditional fields and detailed field completion instructions for the CMS 1500 claim form.

Instructions for completing and submitting electronic claims are available through the X12N Technical Report 3 (TR3) for the 837P (wpc-edi.com), 837P Companion Guide (in the Provider Services Specifications section of the Department's Web site), and in the Web Portal User Guide (via within the portal).

CMS Field #	Field Label	Field is?	Instructions
1	**Insurance Type**	Required	Place an "X" in the box marked as Medicaid.
1a	**Insured's ID Number**	Required	Enter the member's Colorado Medical Assistance Program seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	**Patient's** Name	Required	Enter the member's last name, first name, and middle initial.
3	**Patient's** Date of Birth **/ Sex**	Required	Enter the patient's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070115 for July 1, 2015. Place an "X" in the appropriate box to indicate the sex of the member.
4	**Insured's Name**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's full last name, first name, and middle initial. If the insured used a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name.
5	**Patient's Address**	Not Required	
6	**Patient's Relationship** to Insured	Conditional	Complete if the member is covered by a commercial health insurance policy. Place an "X" in the box that identifies the member's relationship to the policyholder.

CMS Field #	Field Label	Field is?	Instructions
7	**Insured's Address**	Not Required	
8	**Reserved for NUCC Use**		
9	**Other Insured's Name**	Conditional	If field 11d is marked "YES", enter the insured's last name, first name and middle initial.
9a	**Other Insured's Policy or Group Number**	Conditional	If field 11d is marked "YES", enter the policy or group number.
9b	**Reserved for NUCC Use**		
9c	**Reserved for NUCC Use**		
9d	**Insurance Plan or Program Name**	Conditional	If field 11d is marked "YES", enter the insurance plan or program name.
10a-c	**Is Patient's Condition Related to?**	Conditional	When appropriate, place an "X" in the correct box to indicate whether one or more of the services described in field 24 are for a condition or injury that occurred on the job, as a result of an auto accident or other.
10d	**Reserved for Local Use**		
11	**Insured's Policy, Group**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy.

CMS Field #	Field Label	Field is?	Instructions
	or FECA Number		Enter the insured's policy number as it appears on the ID card. Only complete if field 4 is completed.
11a	**Insured's Date of Birth, Sex**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's birth date using two digits for the month, two digits for the date and two digits for the year. Example: 070115 for July 1, 2015. Place an "X" in the appropriate box to indicate the sex of the insured.
11b	**Other Claim ID**	Not Required	
11c	**Insurance Plan Name or Program Name**	Not Required	
11d	**Is there another Health Benefit Plan?**	Conditional	When appropriate, place an "X" in the correct box. If marked "YES", complete 9, 9a and 9d.
12	**Patient's or Authorized Person's signature**	Required	Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File". Enter the date the claim form was signed.
13	**Insured's or Authorized Person's Signature**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
14	**Date of Current Illness Injury or Pregnancy**	Conditional	Complete if information is known. Enter the date of illness, injury or pregnancy, (date of the last menstrual period) using two digits for the month, two digits for the date and two digits for the year. Example: 070115 for July 1, 2015. Enter the applicable qualifier to identify which date is being reported 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period
15	**Other Date**	Not Required	
16	**Date Patient Unable to Work in Current Occupation**	Not Required	
17	**Name of Referring Physician**	Not Required	
17.b	**NPI of referring physician**	Required	Required in accordance with Program Rule 8.125.8.A
18	**Hospitalization Dates Related to Current Service**	Conditional	Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge using two digits for the month, two digits for the date and two digits for the year. Example: 070115 for July 1, 2015. If the member is still hospitalized, the discharge date may be omitted. This information is not edited.
19	**Additional Claim Information**	Conditional	**LBOD** Use to document the Late Bill Override Date for timely filing.

CMS Field #	Field Label	Field is?	Instructions
20	**Outside Lab?** **$ Charges**	Not Required	
21	**Diagnosis or Nature of Illness or Injury**	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-9-CM (DOS 9/30/15 and before)
22	**Medicaid Resubmission Code**	Conditional	List the original reference number for adjusted claims. When resubmitting a claim as a replacement or a void, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.
23	**Prior Authorization**	Not Required	
24	**Claim Line Detail**	Information	The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line. **Do not enter more than six lines of information** on the paper claim. If more than six lines of information are entered, the additional lines will not be entered for processing. Each claim form must be fully completed (totaled). **Do not file continuation claims** (e.g., Page 1 of 2).

CMS Field #	Field Label	Field is?	Instructions
24A	**Dates of Service**	Required	The field accommodates the entry of two dates: a "From" date of services and a "To" date of service. Enter the date of service using two digits for the month, two digits for the date and two digits for the year. Example: 010116 for January 1, 2016 From To **01 01 16** | | | | | | Or From To **01 01 16 01 01 16** Span dates of service From To **01 01 16 01 31 16** Single Date of Service: Enter the six digit date of service in the "From" field. Completion of the "To field is not required. Do not spread the date entry across the two fields. Span billing: permissible if the same service (same procedure code) is provided on consecutive dates. **Supplemental Qualifier** To enter supplemental information, begin at 24A by entering the qualifier and then the information. ZZ Narrative description of unspecified code N4 National Drug Codes VP Vendor Product Number OZ Product Number CTR Contract Rate JP Universal/National Tooth Designation JO Dentistry Designation System for Tooth & Areas of Oral Cavity

CMS Field #	Field Label	Field is?	Instructions
24B	**Place of Service**	Required	Enter the Place of Service (POS) code that describes the location where services were rendered. The Colorado Medical Assistance Program accepts the CMS place of service codes. 04 Homeless Shelter 11 Office 12 Home 15 Mobile Unit 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room Hospital 25 Birthing Center 26 Military Treatment Center 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Transportation – Land 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility – MR 60 Mass Immunization Center 61 Comprehensive IP Rehab Facility 62 Comprehensive OP Rehab Facility 65 End Stage Renal Dialysis Trtmt Facility 71 State-Local Public Health Clinic 99 Other Unlisted

CMS Field #	Field Label	Field is?	Instructions
24C	**EMG**	Conditional	Enter a "Y" for YES or leave blank for NO in the bottom, unshaded area of the field to indicate the service is rendered for a life-threatening condition or one that requires immediate medical intervention. If a "Y" for YES is entered, the service on this detail line is exempt from co-payment requirements.
24D	**Procedures, Services, or Supplies**	Required	Enter the HCPCS procedure code that specifically describes the service for which payment is requested. All procedures must be identified with codes in the current edition of Physicians Current Procedural Terminology (CPT). CPT is updated annually. HCPCS Level II Codes The current Medicare coding publication (for Medicare crossover claims only). Only approved codes from the current CPT or HCPCS publications will be accepted.
24D	**Modifier**	Required	Enter the appropriate procedure-related modifier that applies to the billed service. Up to four modifiers may be entered when using the paper claim form. GN **Service By Speech/Language Pathologist** HB **Habilitative therapy service** TL **Early Intervention service**
24E	**Diagnosis Pointer**	Required	Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis. At least one diagnosis code reference letter must be entered. When multiple services are performed, the primary reference letter for each

CMS Field #	Field Label	Field is?	Instructions
			service should be listed first, other applicable services should follow. This field allows for the entry of 4 characters in the unshaded area.
24F	$ **Charges**	Required	Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number. Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply. The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed. Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service. Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from the usual and customary charges.
24G	**Days or Units**	Required	Enter the number of services provided for each procedure code. Enter whole numbers only- do not enter fractions or decimals.
24H	**EPSDT/Family Plan**	Conditional	**EPSDT** (shaded area) For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows: AV Available- Not Used

CMS Field #	Field Label	Field is?	Instructions
			S2 Under Treatment ST New Service Requested NU Not Used **Family Planning** (unshaded area) Not Required
24I	**ID Qualifier**	Not Required	
24J	**Rendering Provider ID #**	Required	In the shaded portion of the field, enter the eight-digit Colorado Medical Assistance Program provider number assigned to the individual who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic. NOTE: When billing a paper claim form, do not use the individual's NPI.
25	**Federal Tax ID Number**	Not Required	
26	**Patient's Account Number**	Optional	Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report (PCR).
27	**Accept Assignment?**	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28	**Total Charge**	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	**Amount Paid**	Conditional	Enter the total amount paid by Medicare or any other commercial health insurance that has made payment on the billed services.

CMS Field #	Field Label	Field is?	Instructions
			Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
30	**Rsvd for NUCC Use**		
31	**Signature of Physician or Supplier Including Degrees or Credentials**	Required	Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent. A holographic signature stamp may be used if authorization for the stamp is on file with the fiscal agent. An authorized agent or representative may sign the claim for the enrolled provider if the name and signature of the agent is on file with the fiscal agent. Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070116 for July 1, 2016. **Unacceptable signature alternatives:** Claim preparation personnel may not sign the enrolled provider's name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature. "Signature on file" notation is not acceptable in place of an authorized signature.
32	**32- Service Facility Location Information** **32a- NPI Number**	Conditional	Complete for services provided in a hospital or nursing facility in the following format: 1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code

CMS Field #	Field Label	Field is?	Instructions
	32b- Other ID #		32a- NPI Number Enter the NPI of the service facility (if known). 32b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the service facility (if known). The information in field 32, 32a and 32b is not edited.
33	**33- Billing Provider Info & Ph #** **33a- NPI Number** **33b- Other ID #**	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code 33a- NPI Number Enter the NPI of the billing provider 33b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization.

UB-04 Paper Claim Reference Table

Speech therapy outpatient hospital paper claims must be submitted on the UB-04 claim form.

The information in the following table provides instructions for completing Form Locators (FL) as they appear on the UB-04 paper claim form. Instructions for completing the UB-04 claim form are based on the current *National Uniform Billing Committee (NUBC) UB-04 Reference Manual*. Unless otherwise noted, all data FLs on the UB-04 have the same attributes (specifications) for the Colorado Medical Assistance Program as those indicated in the *NUBC UB-04 Reference Manual*.

All code values listed in the *NUBC UB-04 Reference Manual* for each FL **may not** be used for submitting paper claims to the Colorado Medical Assistance Program. The appropriate code values listed in this manual must be used when billing the Colorado Medical Assistance Program.

The UB-04 certification must be completed and attached to all claims submitted on the UB-04. A copy of the certification form is included with this manual. Completed UB-04 paper Colorado Medical Assistance Program claims, including hardcopy Medicare claims, should be mailed to the correct fiscal agent address located in Appendix A of the Appendices section in Provider Services Billing Manuals.

Do not submit "continuation" claims. Each claim form has a set number of billing lines available for completion. Do not crowd more lines on the form. Billing lines in excess of the designated number are not processed or acknowledged. Claims with more than one page may be submitted electronically.

The Paper Claim Reference Table below lists the required, optional and/or conditional form locators for submitting the UB-04 paper claim form to the Colorado Medical Assistance Program for speech therapy services.

Instructions for completing and submitting electronic claims are available through the X12N Technical Report 3 (TR3) for the 837I (wpc-edi.com), 837I Companion Guide (in the Provider Services Specifications section of the Department's website), and in the Web Portal 837I User Guide (via within the portal).

Form Locator and Label	Completion Format	Instructions
1. Billing Provider Name, Address, Telephone Number	Text	Required Enter the provider or agency name and complete mailing address of the provider who is billing for the services: Street/Post Office box City State Zip Code Abbreviate the state using standard post office abbreviations. Enter the telephone number.

Form Locator and Label	Completion Format	Instructions
2. Pay-to Name, Address, City, State	Text	Required if different from FL 1. Enter the provider or agency name and complete mailing address of the provider who will receive payment for the services: Street/Post Office box City State Zip Code Abbreviate the state using standard post office abbreviations. Enter the telephone number.
3a. Patient Control Number	Up to 20 characters: Letters, numbers or hyphens	Optional Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Provider Claim Report.
3b. Medical Record Number	17 digits	Optional Enter the number assigned to the patient to assist in retrieval of medical records.
4. Type of Bill	3 digits	Required Enter the three digit number indicating the specific type of bill. The three digit code requires one digit each in the following sequences (Type of facility, Bill classification, and Frequency): **Digit 1 — Type of Facility** 1 Hospital 2 Skilled Nursing Facility 3 Home Health 4 Religious Non-Medical Health Care Institution Hospital Inpatient 5 Religious Non-Medical Health Care Institution Post-Hospital Extended Care Services 6 Intermediate Care 7 Clinic (Rural Health/FQHC/Dialysis Center)

Form Locator and Label	Completion Format	Instructions
		8 Special Facility (Hospice, RTCs) **Digit 2** **Bill Classification (Except clinics & special facilities):** 1 Inpatient (Including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment) 5 Intermediate Care Level I 6 Intermediate Care Level II 7 Sub-Acute Inpatient (revenue code 19X required with this bill type) 8 Swing Beds 9 Other **Digit 2** **Bill Classification (Clinics Only):** 1 Rural Health/FQHC 2 Hospital Based or Independent Renal Dialysis Center 3 Freestanding 4 Outpatient Rehabilitation Facility (ORF) 5 Comprehensive Outpatient Rehabilitation Facilities (CORFs) 6 Community Mental Health Center **Digit 2** **Bill Classification (Special Facilities Only):** 1 Hospice (Non-Hospital Based) 2 Hospice (Hospital Based) 3 Ambulatory Surgery Center

Form Locator and Label	Completion Format	Instructions
		4 Freestanding Birthing Center 5 Critical Access Hospital 6 Residential Facility **Digit 3** **Frequency:** 00 Non-Payment/Zero Claim 01 Admit through discharge claim 02 Interim - First claim 03 Interim - Continuous claim 04 Interim - Last claim 07 Replacement of prior claim 08 Void of prior claim
5. Federal Tax Number	None	Not required Submitted information is not entered into the claim processing system.
6. Statement Covers Period – From/Through	From: 6 digits MMDDYY Through: 6 digits MMDDYY	Required (Note: OP claims cannot span over a month's end) Enter the From (beginning) date and Through (ending) date of service covered by this bill. *Example:* 01012016 = January 1, 2016 This form locator must reflect the beginning and ending dates of service. When span billing for multiple dates of service and multiple procedures, complete FL 45 (Service Date). Providers not wishing to span bill following these guidelines, must submit one claim per date of service. "From" and "Through" dates must be the same. All line item entries must represent the same date of service.
8a. Patient Identifier		Not required Submitted information is not entered into the claim processing system.
8b. Patient Name	Up to 25 characters:	Required Enter the member's last name, first name and middle initial.

Form Locator and Label	Completion Format	Instructions
	Letters & spaces	
9a. Patient Address – Street	Characters Letters & numbers	Required Enter the member's street/post office box as determined at the time of admission.
9b. Patient Address – City	Text	Required Enter the member's city as determined at the time of admission.
9c. Patient Address – State	Text	Required Enter the member's state as determined at the time of admission.
9d. Patient Address – Zip	Digits	Required Enter the member's zip code as determined at the time of admission.
9e. Patient Address – Country Code	Digits	Optional
10. Birthdate	8 digits (MMDDCCYY)	Required Enter the member's birthdate using two digits for the month, two digits for the date, and four digits for the year. *Example*: 01012015 = January 1, 2015
11. Patient Sex	1 letter	Required Enter an M (male) or F (female) to indicate the member's sex.
12. Admission Date	6 digits	Conditional Required for observation holding beds only
13. Admission Hour	6 digits	Conditional Required for observation holding beds only
14. Admission Type	1 digit	Required Enter the following to identify the admission priority:

Form Locator and Label	Completion Format	Instructions
		1 – Emergency Member requires immediate intervention as a result of severe, life threatening or potentially disabling conditions. Exempts inpatient hospital & clinic claims from co-payment and PCP referral. Exempts outpatient hospital claims from co-payment and PCP only if revenue code 450 or 459 is present. This is the only benefit service for an undocumented alien. If span billing, emergency services cannot be included in the span bill and must be billed separately from other outpatient services. **2 - Urgent** The member requires immediate attention for the care and treatment of a physical or mental disorder. **3 - Elective** The member's condition permits adequate time to schedule the availability of accommodations. **4 - Newborn** Required for inpatient and outpatient hospital. **5 - Trauma Center** Visit to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving trauma activation. **Clinics** Required only for emergency visit.
15. Source of Admission	1 digit	Required Enter the appropriate code for co-payment exceptions on claims submitted for outpatient services. (To be used in conjunction with FL 14, Type of Admission). 1 Physician referral

Form Locator and Label	Completion Format	Instructions
		2 Clinic referral 4 Transfer from a hospital 5 Transfer from a skilled nursing facility (SNF) 6 Transfer from another health care facility 8 Court/Law Enforcement 9 Information not available E Transfer from an Ambulatory Surgery Center F Transfer from a Hospice Agency **Newborns** 5 Baby born inside this hospital 6 Baby born outside this hospital
16. Discharge Hour	2 digits	Not Required
17. Patient Discharge Status	2 digits	Conditional Enter patient status as of discharge date. 01 Discharged to Home or Self Care (Dialysis is limited to code 01) 02 Discharged/transferred to another short term hospital 03 Discharged/transferred to a Skilled Nursing Facility (SNF) 04 Discharged/transferred to an Intermediate Care Facility (ICF) 05 Discharged/transferred to another type institution 06 Discharged/transferred to home under care of organized Home and Community Based Services Program (HCBS) 07 Left against medical advice or discontinued care 08 Discharged/transferred to home under care of a Home Health provider 09 Admitted as an inpatient to this hospital 20 Expired

Form Locator and Label	Completion Format	Instructions
		30** Still a patient or expected to return for outpatient services 31** Still a patient - Awaiting transfer to long term psychiatric hospital 32** Still a Patient - Awaiting placement by Colorado Medical Assistance Program 50 Hospice – Home 51 Hospice - Medical Facility 61 Discharged/transferred within this institution to hospital based Medicare approved swing bed 62 Discharged/transferred to an inpatient rehabilitation hospital. 63 Discharged/transferred to a Medicare certified long term care hospital. 65 Discharge/Transferred to a Psychiartric Hospital or Psychiatric Distinct Part Unit of a Hospital 66 Transfered/Discharged to Critical Access Hospital CAH 70 Discharged/Transferd to Other HC Insitution 71 Discharged/transferred/referred to another institution for outpatient services 72 Discharged/transferred/referred to this institution for outpatient services Use code 02 for a PPS hospital transferring a patient to another PPS hospital. Code 05, Discharged to Another Type Institution, is the most appropriate code to use for a PPS hospital transferring a patient to an exempt hospital. **A PPS hospital cannot use Patient Status codes 30, 31 or 32 on any claim submitted for DRG reimbursement. The code(s) are valid for use on exempt hospital claims only. Interim bills may be submitted for Prospective Payment System (PPS) -DRG claims, but must meet specific billing requirements.

Form Locator and Label	Completion Format	Instructions
		For exempt hospitals use the appropriate code from the codes listed. Note: Refer to the "Interim" billing instruction in this section of the manual.
18-28. Condition Codes	2 Digits	Conditional Complete with as many codes necessary to identify conditions related to this bill that may affect payer processing. **Condition Codes** 01 Military service related 02 Employment related 04 HMO enrollee 05 Lien has been filed 06 ESRD patient - First 18 months entitlement 07 Treatment of non-terminal condition/hospice patient 17 Patient is homeless 25 Patient is a non-US resident 39 Private room medically necessary 42 Outpatient Continued Care not related to Inpatient 44 Inpatient CHANGED TO Outpatient 51 Outpatient Non-diagnostic Service unrelated to Inpatinet admit 60 DRG (Day outlier) **Renal dialysis settings** 71 Full care unit 72 Self care unit 73 Self care training 74 Home care 75 Home care - 100 percent reimbursement 76 Back-up facility **Special Program Indicator Codes** A1 EPSDT/CHAP A2 Physically Handicapped Children's Program A4 Family Planning A6 PPV/Medicare

Form Locator and Label	Completion Format	Instructions
		A9 Second Opinion Surgery AA Abortion Due to Rape AB Abortion Done Due to Incest AD Abortion Due to Life Endangerment AI Sterilization B3 Pregnancy Indicator B4 Admission Unrelated to Discharge **PRO Approval Codes** C1 Approved as billed C2 Automatic approval as billed - Based on focused review C3 Partial approval C4 Admission/Services denied C5 Post payment review applicable C6 Admission preauthorization C7 Extended authorization
29. Accident State		Optional
31-34. Occurrence Code/Date	2 digits and 6 digits	Conditional Complete both the code and date of occurrence. Enter the appropriate code and the date on which it occurred. Enter the date using MMDDYY format. **Occurrence Codes:** 01 Accident/Medical Coverage 02 Auto Accident - No Fault Liability 03 Accident/Tort Liability 04 Accident/Employment Related 05 Other Accident/No Medical Coverage or Liability Coverage 06 Crime Victim 20 Date Guarantee of Payment Began 24* Date Insurance Denied 25* Date Benefits Terminated by Primary Payer 26 Date Skilled Nursing Facility Bed Available

Form Locator and Label	Completion Format	Instructions
		27 Date of Hospice Certification or Re-certification 40 Scheduled Date of Admission (RTD) 50 Medicare Pay Date 51 Medicare Denial Date 53 Late Bill Override Date 55 Insurance Pay Date A3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer A indicated in FL 50 B3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer B indicated in FL 50 C3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer C indicated in FL 50 **Other Payer occurrence codes 24 and 25 must be used when applicable. The claim must be submitted with the third party information.*
35-36. Occurrence Span Code From/ Through	2 digits and 6 digits	Leave blank
38. Responsible Party Name/ Address	None	Not required Submitted information is not entered into the claim processing system.
39-41. Value Code-Code Value Code-Amount	2 characters and 9 digits	Conditional Enter appropriate codes and related dollar amounts to identify monetary data or number of days using whole numbers, necessary for the processing of this claim. Never enter negative amounts. If a value code is entered, a dollar amount or numeric value related to the code must always be entered.

Form Locator and Label	Completion Format	Instructions
		01 Most common semiprivate rate (Accommodation Rate) 06 Medicare blood deductible 14 No fault including auto/other 15 Worker's Compensation 30 Preadmission testing 31 Patient Liability Amount 32 Multiple Patient Ambulance Transport 37 Pints of Blood Furnished 38 Blood Deductible Pints 40 New Coverage Not Implemented by HMO 45 Accident Hour Enter the hour when the accident occurred that necessitated medical treatment. Use the same coding used in FL 18 (Admission Hour). 49 Hematocrit Reading - EPO Related 58 Arterial Blood Gas (PO2/PA2) 68 EPO-Drug 80 Covered Days 81 Non-Covered Days Enter the deductible amount applied by indicated payer: A1 Deductible Payer A B1 Deductible Payer B C1 Deductible Payer C Enter the amount applied to member's co-insurance by indicated payer: A2 Coinsurance Payer A B2 Coinsurance Payer B C2 Coinsurance Payer C Enter the amount paid by indicated payer: A3 Estimated Responsibility Payer A B3 Estimated Responsibility Payer B C3 Estimated Responsibility Payer C Enter the amount paid by member FC Patient Paid Amount

Form Locator and Label	Completion Format	Instructions
		For Rancho Coma Score bill with appropriate diagnosis for head injury. Medicare & TPL - See A1-A3, B1-B3, & C1-C3 above
42. Revenue Code	3 digits	Required Enter the revenue code which identifies the specific accommodation or ancillary service provided. List revenue codes in ascending order. A revenue code must appear only once per date of service. If more than one of the same service is provided on the same day, combine the units and charges on one line accordingly. When billing outpatient hospital radiology, the radiology revenue code may be repeated, but the corresponding HCPCS code cannot be repeated for the same date of service. Refer to instructions under FL 44 (HCPCS/Rates). Psychiatric step down Use the following revenue codes: 114 Psychiatric Step Down 1 124 Psychiatric Step Down 2
43. Revenue Code Description	Text	Required Enter the revenue code description or abbreviated description. When reporting an NDC Enter the NDC qualifier of "N4" in the first two positions on the left side of the field. Enter the 11-digit NDC numeric code Enter the NDC unit of measure qualifier (examples include): F2 – International Unit GR – Gram ML – Milliliter UN – Units Enter the NDC unit of measure quantity

Form Locator and Label	Completion Format	Instructions
44. HCPCS/Rates /HIPPS Rate Codes	5 digits	Conditional Enter only the HCPCS code for each detail line. Use approved modifiers listed in this section for hospital based transportation services. Complete for laboratory, radiology, physical therapy, occupational therapy, and hospital based transportation. When billing HCPCS codes, the appropriate revenue code must also be billed. HCPCS codes must be identified for the following revenue codes: ▪ 30X LABORATORY ▪ 32X RADIOLOGY – DIAGNOSTIC ▪ 33X RADIOLOGY – THERAPEUTIC ▪ 34X NUCLEAR MEDICINE ▪ 35X CT SCAN ▪ 40X OTHER IMAGING SERVICES ▪ 42X PHYSICAL THERAPY ▪ 43X OCCUPATIONAL THERAPY ▪ 44X SPEECH THERAPY ▪ 54X AMBULANCE ▪ 61X MRI HCPCS codes cannot be repeated for the same date of service. Combine the units in FL 46 (Service Units) to report multiple services. The following revenue codes always require a HCPCS code. Please reference the Provider Services Bulletins section of the Department's Web site for a list of physician-administered drugs that also require an NDC code. When a HCPCS code is repeated more than once per day and billed on separate lines, use modifier 76 to indicate this is a repeat procedure and not a duplicate. 0252 Non-Generic Drugs 0253 Take Home Drugs 0255 Drugs Incident to Radiology 0257 Non-Prescription 0258 IV Solutions

Form Locator and Label	Completion Format	Instructions
		0259 Other Pharmacy 0260 IV Therapy General Classification 0261 Infusion Pump 0262 IV Therapy/Pharmacy Services 0263 IV Therapy/Drug/Supply Delivery 0264 IV Therapy/Supplies 0269 Other IV Therapy 0631 Single Source Drug 0632 Multiple Source Drug 0633 Restrictive Prescription 0634 Erythropoietin (EPO) <10,000 0635 Erythropoietin (EPO) >10,000 0636 Drugs Requiring Detailed Coding
45. Service Date	6 digits	Required For span bills only Enter the date of service using MMDDYY format for each detail line completed. Each date of service must fall within the date span entered in the "Statement Covers Period" (FL 6). Not required for single date of service claims.
46. Service Units	3 digits	Required Enter a unit value on each line completed. Use whole numbers only. Do not enter fractions or decimals and do not show a decimal point followed by a 0 to designate whole numbers (e.g., Do not enter 1.0 to signify one unit) The grand total line (Line 23) does not require a unit value. For span bills, the units of service reflect only those visits, miles or treatments provided on dates of service in FL 45.
47. Total Charges	9 digits	Required Enter the total charge for each line item. Calculate the total charge as the number of units multiplied by the unit charge. Do not subtract Medicare or third party payments from line charge entries. Do

Form Locator and Label	Completion Format	Instructions
		not enter negative amounts. A grand total in line 23 is required for all charges.
48. Non-Covered Charges	9 digits	Conditional Enter incurred charges that are not payable by the Colorado Medical Assistance Program. Non-covered charges must be entered in both FL 47 (Total Charges) and FL 48 (Non-Covered Charges). Each column requires a grand total. Non-covered charges cannot be billed for outpatient hospital laboratory or hospital based transportation services.
50. Payer Name	1 letter and text	Required Enter the payment source code followed by name of each payer organization from which the provider might expect payment. At least one line must indicate The Colorado Medical Assistance Program. Source Payment Codes B Workmen's Compensation C Medicare D Colorado Medical Assistance Program E Other Federal Program F Insurance Company G Blue Cross, including Federal Employee Program H Other - Inpatient (Part B Only) I Other Line A Primary Payer Line B Secondary Payer Line C Tertiary Payer
51. Health Plan ID	8 digits	Required Enter the provider's Health Plan ID for each payer name. Enter the eight digit Colorado Medical Assistance

Form Locator and Label	Completion Format	Instructions
		Program provider number assigned to the **billing provider**. Payment is made to the enrolled provider or agency that is assigned this number.
52. Release of Information		Not required Submitted information is not entered into the claim processing system.
53. Assignment of Benefits		Not required Submitted information is not entered into the claim processing system.
54. Prior Payments	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter third party and/or Medicare payments.
55. Estimated Amount Due	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter the net amount due from The Colorado Medical Assistance Program after provider has received other third party, Medicare or patient liability amount. **Medicare Crossovers** Enter the sum of the Medicare coinsurance plus Medicare deductible less third party payments and patient payments.
56. National Provider Identifier (NPI)	10 digits	Optional Enter the billing provider's 10-digit National Provider Identifier (NPI).
57. Other Provider ID		Not required Submitted information is not entered into the claim processing system.
58. Insured's Name	Up to 30 characters	Required Enter the member's name on the Colorado Medical Assistance Program line.

Form Locator and Label	Completion Format	Instructions
		Other Insurance/Medicare Complete additional lines when there is third party coverage. Enter the policyholder's last name, first name, and middle initial.
60. Insured's Unique ID	Up to 20 characters	Required Enter the insured's unique identification number assigned by the payer organization exactly as it appears on the health insurance card. Include letter prefixes or suffixes shown on the card.
61. Insurance Group Name	14 letters	Conditional Complete when there is third party coverage. Enter the name of the group or plan providing the insurance to the insured exactly as it appears on the health insurance card.
62. Insurance Group Number	17 digits	Conditional Complete when there is third party coverage. Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is carried.
63. Treatment Authorization Code	Up to 18 characters	Conditional Complete when the service requires a PAR. Enter the authorization number in this FL if a PAR is required and has been approved for services.
64. Document Control Number		Not required Submitted information is not entered into the claim processing system.
65. Employer Name	Text	Conditional Complete when there is third party coverage. Enter the name of the employer that provides health care coverage for the individual identified in FL 58 (Insured Name).
66. Diagnosis Version Qualifier		Not required Submitted information is not entered into the claim processing system.

Form Locator and Label	Completion Format	Instructions
67. Principal Diagnosis Code	Up to 6 digits	Required Enter the exact diagnosis code describing the principal diagnosis that exists at the time of admission or develops subsequently and affects the length of stay. Do not add extra zeros to the diagnosis code.
67A- 67Q. Other Diagnosis	Up to 6 digits	Conditional Enter the exact diagnosis code corresponding to additional conditions that co-exist at the time of admission or develop subsequently and which effect the treatment received or the length of stay. Do not add extra zeros to the diagnosis code.
69. Admitting Diagnosis Code	Up to 6 digits	Optional Enter the diagnosis code as stated by the physician at the time of admission.
70. Patient Reason Diagnosis		Not required Submitted information is not entered into the claim processing system.
71. PPS Code		Not required Submitted information is not entered into the claim processing system.
72. External Cause of Injury Code (E-code)	Up to 6 digits	Optional Enter the diagnosis code for the external cause of an injury, poisoning, or adverse effect. This code must begin with an "E".
74. Principal Procedure Code/ Date	Up to 7 characters or Up to 6 digits	Conditional Enter the procedure code for the principal procedure performed during this billing period and the date on which procedure was performed. Enter the date using MMDDYY format. Apply the following criteria to determine the principle procedure: The principal procedure is not performed for diagnostic or exploratory purposes. This code is related to definitive treatment; and The principal procedure is most related to the primary diagnosis.

Form Locator and Label	Completion Format	Instructions
74A. Other Procedure Code/Date	Up to 7 characters or Up to 6 digits	Conditional Complete when there are additional significant procedure codes. Enter the procedure codes identifying all significant procedures other than the principle procedure and the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principle diagnosis. Enter the date using MMDDYY format.
76. Attending **NPI – Conditional** **QUAL - Conditional** **ID - (Colorado Medical Assistance Provider #) – Required** **Attending- Last/ First Name**	NPI - 10 digits QUAL – Text Medicaid ID - 8 digits Text	Colorado Medical Assistance Program ID Required NPI - Enter the 10-digit NPI and eight-digit Colorado Medical Assistance Program provider number assigned to the physician having primary responsibility for the patient's medical care and treatment. This number is obtained from the physician, and cannot be a clinic or group number. (If the attending physician is not enrolled in the Colorado Medical Assistance Program or if the member leaves the ER before being seen by a physician, the hospital may enter their individual numbers.) Hospitals may enter the member's regular physician's 10-digit NPI and Medical Assistance Program provider ID in the Attending Physician ID form locator if the locum tenens physician is not enrolled in the Colorado Medical Assistance Program. QUAL – Enter "1D " for Medicaid Enter the attending physician's last and first name. This form locator must be completed for all services.
77. Operating- NPI/QUAL/ID		Not required Submitted information is not entered into the claim processing system.
78-79. Other ID **NPI – Conditional**	NPI - 10 digits QUAL – Text	Conditional – Colorado Medical Assistance Program ID (see below)

Form Locator and Label	Completion Format	Instructions
QUAL - Conditional **ID - (Colorado Medical Assistance Provider #) – Conditional**	Medicaid ID - 8 digits	Complete when attending physician is not the PCP or to identify additional physicians. NPI - Enter up to two 10-digit NPI and eight digit physician Colorado Medical Assistance Program provider numbers, when applicable. This form locator identifies physicians other than the attending physician. If the attending physician is not the PCP or if a clinic is a PCP agent, enter the PCP eight digit Colorado Medical Assistance Program provider number as the referring physician. The name of the Colorado Medical Assistance Program member's PCP appears on the eligibility verification. Review either for eligibility and PCP. The Colorado Medical Assistance Program does not require that the PCP number appear more than once on each claim submitted. The attending physician's last and first name are optional.
80. Remarks	Text	Optional Enter specific additional information necessary to process the claim or fulfill reporting requirements.
81. Code-Code QUAL/CODE/VALUE (a-d)		Optional Submitted information is not entered into the claim processing system.

COLORADO
Department of Health Care Policy & Financing

Institutional Provider Certification

This is to certify that the foregoing information is true, accurate and complete.

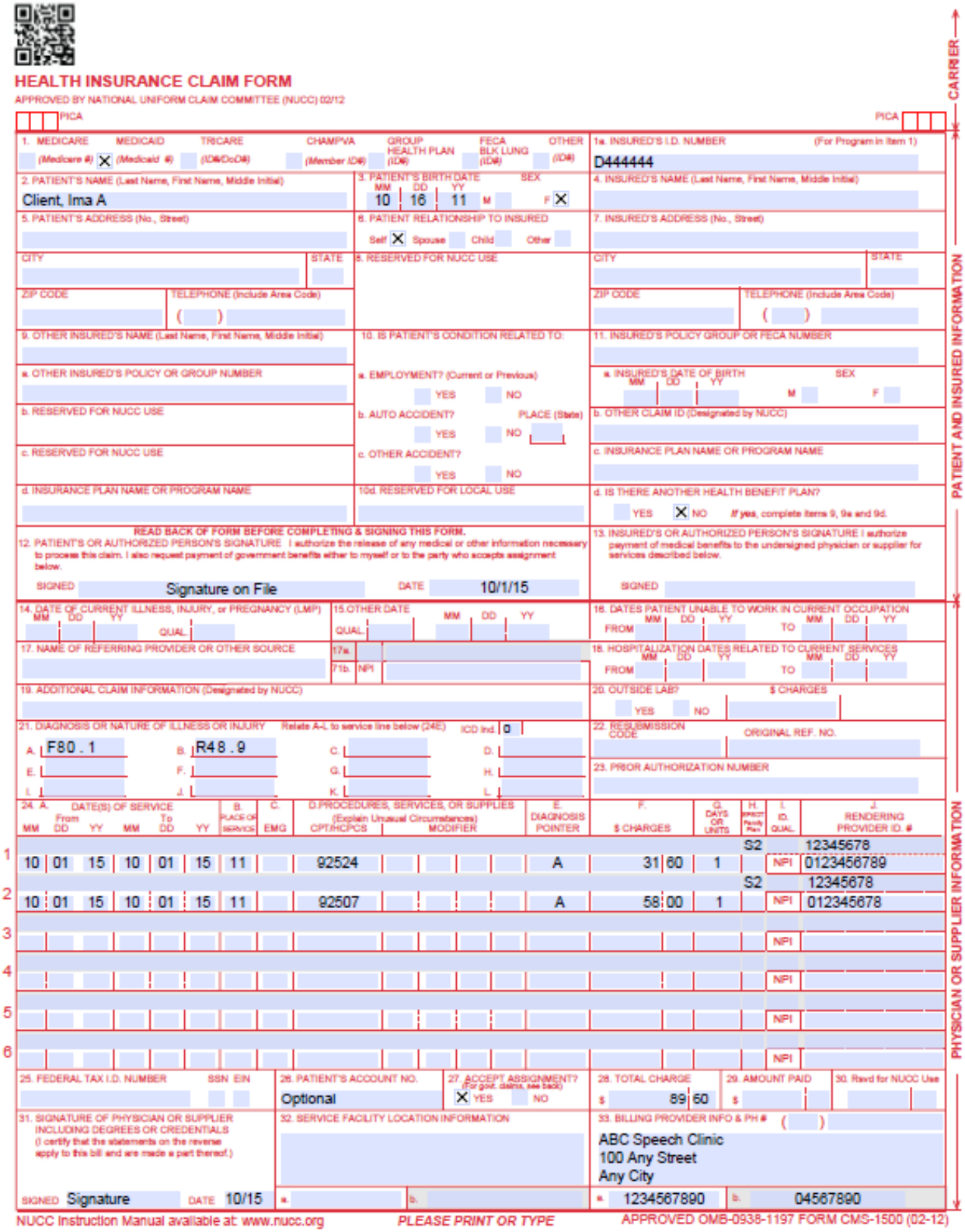
This is to certify that I understand that payment of this claim will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State Laws.

Signature:_____

Date:_____

This document is an addendum to the UB-04 claim form and is required per 42 C.F.R. 445.18 (a) (1-2) to be attached to paper claims submitted on the UB-04.

CMS 1500 Speech Therapy Claim Example



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): D444444

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Client, Ima A

3. PATIENT'S BIRTH DATE MM DD YY: 10 16 11 SEX M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M | F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES | NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO X If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE 10/1/15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. F80.1 B. R48.9 C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 01 15	10 01 15	11		92524		A	31 60	1		S2 NPI	12345678 0123456789
2	10 01 15	10 01 15	11		92507		A	58 00	1		S2 NPI	12345678 012345678
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. Optional

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X | NO

28. TOTAL CHARGE $ 89 60

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Signature DATE 10/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

ABC Speech Clinic
100 Any Street
Any City

a. 1234567890 b. 04567890

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

UB-04 Outpatient Speech Therapy Claim Example

1	2	3a PAT. CNTL #		4 TYPE OF BILL
City Hospital 100 Saginaw St. Anytown, CO 80000 303-333-3333		b. MED. REC. #		131
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 02/06/16 THROUGH 02/06/16	7

8 PATIENT NAME	9 PATIENT ADDRESS
a	a 123 Main Street
b Client, Ima	b Anytown c CO d 80000 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
01/04/2006	F			3	3					

31–34 OCCURRENCE CODE / DATE; 35–36 OCCURRENCE SPAN CODE / FROM / THROUGH; 37

38

39–41 VALUE CODES CODE / AMOUNT (a, b, c, d)

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
440	Speech Therapy	92502	02/06/16	1	27.92		
440	Speech Therapy	92507	02/06/16	1	21.64		
	PAGE 1 OF 1	CREATION DATE		TOTALS	49.56		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
A D - Medicaid	12345678					57 OTHER PRV ID

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Client, Ima		Y123456		

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX I63.50 | 67 | 68

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75 | 76 ATTENDING NPI QUAL LAST FIRST

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE | 77 OPERATING NPI QUAL LAST FIRST

80 REMARKS | 81CC a b c d | 78 OTHER NPI QUAL LAST FIRST | 79 OTHER NPI QUAL LAST FIRST

UB-04 CMS-1450 © 2005 NUBC OMB APPROVAL PENDING NUBC National Uniform Billing Committee LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

F245-367-000

Late Bill Override Date

For electronic claims, a delay reason code must be selected and a date must be noted in the "Claim Notes/LBOD" field.

Valid Delay Reason Codes

1 Proof of Eligibility Unknown or Unavailable

3 Authorization Delays

7 Third Party Processing Delay

8 Delay in Eligibility Determination

9 Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules

11 Other

The Late Bill Override Date (LBOD) allows providers to document compliance with timely filing requirements when the initial timely filing period has expired. Colorado Medical Assistance Program providers have 120 days from the date of service to submit their claim. For information on the 60-day resubmission rule for denied/rejected claims, please see the General Provider Information manual in the Provider Services Billing Manuals section.

Making false statements about timely filing compliance is a misrepresentation and falsification that, upon conviction, makes the individual who prepares the claim and the enrolled provider subject to fine and imprisonment under state and/or federal law.

Billing Instruction Detail	Instructions
LBOD Completion Requirements	• Electronic claim formats provide specific fields for documenting the LBOD. • Supporting documentation must be kept on file for 6 years. • For paper claims, follow the instructions appropriate for the claim form you are using. ➢ *UB-04*: Occurrence code 53 and the date are required in FL 31-34. ➢ *CMS 1500*: Indicate "LBOD" and the date in box 19 – Additional Claim Information. ➢ *2006 ADA Dental*: Indicate "LBOD" and the date in box 35 - Remarks
Adjusting Paid Claims	If the initial timely filing period has expired and a previously submitted claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day

Billing Instruction Detail	Instructions
	follow-up period was paid and now needs to be adjusted, resulting in additional payment to the provider. **Adjust the claim within 60 days** of the claim payment. Retain all documents that prove compliance with timely filing requirements. *Note: There is no time limit for providers to adjust paid claims that would result in repayment to the Colorado Medical Assistance Program.* **LBOD** = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.
Denied Paper Claims	If the initial timely filing period has expired and a previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was denied. **Correct the claim errors and refile within 60 days** of the claim denial or rejection. Retain all documents that prove compliance with timely filing requirements. **LBOD** = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the denial.
Returned Paper Claims	A previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was returned for additional information. **Correct the claim errors and re-file within 60 days** of the date stamped on the returned claim. Retain a copy of the returned claim that shows the receipt or return date stamped by the fiscal agent. **LBOD** = the stamped fiscal agent date on the returned claim.
Rejected Electronic Claims	An electronic claim that was previously entered within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was rejected and information needed to submit the claim was not available to refile at the time of the rejection. **Correct claim errors and refile within 60 days** of the rejection. Maintain a printed copy of the rejection notice that identifies the claim and date of rejection. **LBOD** = the date shown on the claim rejection report.

Billing Instruction Detail	Instructions
Denied/Rejected Due to Member Eligibility	An electronic eligibility verification response processed during the original Colorado Medical Assistance Program timely filing period states that the individual was not eligible but you were subsequently able to verify eligibility. Read also instructions for retroactive eligibility. **File the claim within 60 days** of the date of the rejected eligibility verification response. Retain a printed copy of the rejection notice that identifies the member and date of eligibility rejection. **LBOD** = the date shown on the eligibility rejection report.
Retroactive Member Eligibility	The claim is for services provided to an individual whose Colorado Medical Assistance Program eligibility was backdated or made retroactive. File the claim within 120 days of the date that the individual's eligibility information appeared on state eligibility files. Obtain and maintain a letter or form from the county departments of social services that: • Identifies the patient by name • States that eligibility was backdated or retroactive • Identifies the date that eligibility was added to the state eligibility system. **LBOD** = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.
Delayed Notification of Eligibility	The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired. **File the claim within 60 days** of the date of notification that the individual had Colorado Medical Assistance Program coverage. Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form see Certification & Request for Timely Filing Extension in the Provider Services Forms section) that identifies the member, indicates the effort made to identify eligibility, and shows the date of eligibility notification. • Claims must be filed within 365 days of the date of service. No exceptions are allowed. • This extension is available only if the provider had no way of knowing that the individual had Colorado Medical Assistance Program coverage.

Billing Instruction Detail	Instructions
	• Providers who render services in a hospital or nursing facility are expected to get benefit coverage information from the institution. • The extension does not give additional time to obtain Colorado Medical Assistance Program billing information. • If the provider has previously submitted claims for the member, it is improper to claim that eligibility notification was delayed. **LBOD** = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.
Electronic Medicare Crossover Claims	An electronic claim is being submitted for Medicare crossover benefits within 120 days of the date of Medicare processing/ payment. (Note: On the paper claim form (only), the Medicare SPR/ERA date field documents crossover timely filing and completion of the LBOD is not required.) **File the claim within 120 days** of the Medicare processing/ payment date shown on the SPR/ERA. Maintain the original SPR/ERA on file. **LBOD** = the Medicare processing date shown on the SPR/ERA.
Medicare Denied Services	The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the member does not have Medicare coverage) being submitted within 60 days of the date of Medicare processing/denial. *Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.* **File the claim within 60 days** of the Medicare processing date shown on the SPR/ERA. Attach a copy of the SPR/ERA if submitting a paper claim and maintain the original SPR/ERA on file. **LBOD** = the Medicare processing date shown on the SPR/ERA.
Commercial Insurance Processing	The claim has been paid or denied by commercial insurance. **File the claim within 60 days** of the insurance payment or denial. Retain the commercial insurance payment or denial notice that identifies the patient, rendered services, and shows the payment or denial date. Claims must be filed within 365 days of the date of service. No exceptions are allowed. If the claim is nearing the 365-day limit and the commercial insurance company has not completed processing, file the claim, receive a denial or rejection, and continue filing in

Billing Instruction Detail	Instructions
	compliance with the 60-day rule until insurance processing information is available. **LBOD** = the date commercial insurance paid or denied.
Correspondence LBOD Authorization	The claim is being submitted in accordance with instructions (authorization) from the Colorado Medical Assistance Program for a 60 day filing extension for a specific member, claim, services, or circumstances. **File the claim within 60 days** of the date on the authorization letter. Retain the authorization letter. **LBOD** = the date on the authorization letter.
Member Changes Providers during Obstetrical Care	The claim is for obstetrical care where the patient transferred to another provider for continuation of OB care. The prenatal visits must be billed using individual visit codes but the service dates are outside the initial timely filing period. **File the claim within 60 days** of the last OB visit. Maintain information in the medical record showing the date of the last prenatal visit and a notation that the patient transferred to another provider for continuation of OB care. **LBOD** = the last date of OB care by the billing provider.

Speech Therapy Revisions Log

Revision Date	Additions/Changes	Pages	Made by
10/01/2012	*Stand-alone Speech Therapy Billing Manual created(separated from Physical/Occupational Therapy Manual*	*All*	*mjb*
10/01/2012	*Updated Global information such as Electronic Claim Submission and LBOD*	*3* *54*	*vr*
10/05/2012	*Formatted document.* *Added TOC* *Added CO-1500 and UB-04 claim examples.*	*All* *1* *42-43*	*cc*
10/05/2012	*Reformatted manual* *Added claim examples* *Added TOC*	*All* *41 & 42* *i*	*jg*
1/23/2014	*Significant changes throughout. Added content on Habilitative speech therapy.*	*All*	*as*
02/07/2014	*Paper claim reference table updates:* *17- Added discharge status of 65, 66, 70* *18-28- Added condition codes 42, 44, 51;* *Added special program indicator AA, AB, AD, AI* *Removed A7 and A8* *35-63- Removed IP/OP- Leave blank* *Added 74 and 75* *39-41- Added value code/amount 30* *Added FC to enter amount paid by client* *42- Removed 0134 from psychiatric step down* *44- Added zero to HCPCS*	 *31* *33-34* *37-43* *36-37* *37* *39-40*	*cc*
02/07/2014	*Updated Billing Information* *Formatted* *Updated Claim examples* *Updated TOC*	*11* *Throughout* *47 & 48* *i*	*jg*
05/22/2014	*Updated manual for removal of the Primary Care Physician Program*	*Throughout*	*Mm*
8/29/14	*Replaced all CO 1500 references with CMS 1500*	*Throughout*	*ZS*

8/29/14	*Updated Professional Claim Billing Instructions section with CMS 1500 information.*		*ZS*
8/29/14	*Replaced all client references with member*	*Throughout*	*ZS*
8/29/14	*Replaced CO 1500 claim example with CMS 1500 example*		*ZS*
9/3/2014	*Updated all web links for the Department's new website*	*Throughout*	*MM*
12/08/2014	*Removed Appendix H information, added Timely Filing document information*	*46*	*mc*
04/28/2015	*Changed the word unshaded to shaded*	*24J*	*Bl*
8/20/2015	*Added Allowed Procedure Codes table template*	*12*	*CF*
8/31/15	*Changed font to Tahoma* *Removed icd-9 and changed to icd-10* *Removed cwqi and replaced ColoradoPAR information (phone numbers).* *Added Prior Authorization column to procedure code table*	*Throughout* *8, 18* *5-7*	*JH*
09/09/2015	*Minor formatting changes, updated TOC, and accepted changes*	*throughout*	*bl*
12/1/2015	*Policy clarification for billing members, referring provider and medical necessity reference. Updates to coding table.*	*3, 4,*	*Aw*
12/10/2015	*Reviewed for formatting and grammar.*	*Throughout*	*JH*
2/4/2016	*Included assistive technology assessment policy for speech therapists. Clarified policy on NCCI, Habilitative therapy, school settings.*	*5*	*AW*
06/16/2016	*Updated UB-04 claim image*	*58*	*JH*

Note: In many instances when specific pages are updated, the page numbers change for the entire section. Page numbers listed above, are the page numbers on which the updates/changes occur.